ALBERTA HEALTH - MENTAL HEALTH DIVISION

Fatality Review - Inette John

Submitted by:

Security Review Committee
October, 1991

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ALBERTA HEALTH - MENTAL HEALTH DIVISION

Fatality Review - Inette John

I INTRODUCTION

On August 27, 1991, a former patient entered the Mental Health Division's Mental Health Clinic on the corner of 108 Street and 100 Avenue in Edmonton and stabbed to death, Inette John, a Mental Health Therapist.

Security Review Committee's Purpose

Immediately following this incident, the Department of Alberta Health struck a Committee to review the circumstances surrounding the homicide of Inette John. The review was designed to:

1. Review the security circumstances surrounding the homicide of Inette John (Fatality Report). This satisfies the requirements of the Occupational Health & Safety Act, Section 13, as well as being the will of the Department.

2. Assess the current security provisions in the Mental Health Division's Provincial Community Clinics. These include policies, procedures, standards, practices, and physical/structural layout.

This report will focus only on #1, the Fatality Review. Included is an analysis of the circumstances surrounding the incident, a review of what preventative measures were in place, appropriateness of responses, and recommendations for improvement.

Methodology

The Department's Security Review Committee has the following representation:

- Mr. D. Ehman, Regional Director, Mental Health Community Clinics Branch
- Mr. T. Chugg, Director, Personnel
- Ms. P. Gill, Mental Health Therapist, Mental Health Division Community Clinics
- Mr. H. Gerling, Manager, Government's Corporate Occupational Health & Safety
- Mr. W. Dickson, Senior Investigator, Edmonton Region, Alberta Occupational Health & Safety

- Dr. A. Gordon, Mental Health Division Senior Psychiatrist
- Mr. R. Mariner, Director, Administrative Services
- Mr. D. Malayko, AUPE Occupational Health & Safety

The Committee commenced meeting on September 3, 1991 to begin the Fatality Review.

Prior to the inaugural meeting, Terms of Reference were drafted for review and acceptance.

The first meeting established the need to interview the nine staff who were directly involved with the incident. Other interested individuals and staff in general were invited to participate if they so desired.

Interviews of the above staff were scheduled for September 9, 10, and 11, 1991. A schedule of questions relating to the incident and security were used as the basis of the interviews.

Interviewed were the following:

- Eighteen employees of the Edmonton Clinic including:
  - Nine employees who were directly involved with the incident.
  - Eight concerned staff.
  - One who was the victim's supervisor.
- Two Alberta Family & Social Services staff that had contact with the Mental Health Division's former client.
- A Homicide Unit Detective from the Edmonton City Police Services who investigated the murder.

Additional information was obtained from auditing the former client's file as well as the victim's personnel file and performance evaluations. An Edmonton Police Services Building Security Assessment was conducted after the incident and was presented with accompanying recommendations for security enhancement and remediation.

A Public Works Supply & Services Security Assessment unit has conducted a security inspection of the building. A report is pending.

Mental Health Consultants, Institutional Mental Health Services Branch submitted Remedial Security Recommendations, which were incorporated into the recommendations.

The Alberta Mental Health Management Planning System (AMHMPS) was reviewed and the Regional Director was consulted for the program's

caseload statistical data.

A report on staff security in all of the Provincial Mental Health Division's Clinics has been completed as a companion to this report.

II DESCRIPTION OF 108 STREET MENTAL HEALTH DIVISION CLINIC OPERATION

Program Organization

The Edmonton downtown city Clinic is located on the fifth, sixth, and seventh floors of an office tower on 108 Street and 100 Avenue. Within these three floors is an Adult Assessment and Treatment Program (AATP), a Psychogeriatric Program, a Mental Health Promotion Program and a Rehabilitation Program (Rehab). The latter is on the fifth floor along with an adjoining Regional Administrative office.

The Edmonton Clinic Rehabilitation program consists of a multidisciplinary team of Consulting Psychiatrists; Registered Psychiatric Nurses/Registered Nurses; Social Worker; Psychologist; Occupational Therapist; Therapy Assistants, and Administrative Support Staff. Staffing of the Rehab. Team on the 5th Floor consists of:

- Twenty Clinicians
- Nine part-time Psychiatrists
- Four Administrative Support Staff

The clinical staff are organized into three teams, each with a Supervisor reporting to a Manager. The Manager also supervises the Regional Manager for the Community Agency Support Services plus the Supervisor of the Administrative Support staff. The Community Agency Support Services position supports this team by establishing and maintaining funded services for the chronically mentally ill. Such services include day programmes extended to the Clinic, Group Homes, and an Approved Home (Residential) Program.

Client Population

The chronically mentally ill patients, number approximately 1,500-2,000 per year, and seek assessment, treatment and case management, (post discharge follow-up with medication, residential placement, and day programs) from the Rehabilitation Program. They have a history of illness requiring hospitalization and often have records of more than one admission. Most require treatment all of their lives and remain on Mental Health Division caseloads indefinitely, unless admitted for a long stay to hospital or refuse Mental Health

Division services. Behaviour ranges from the compliant, co-operative, withdrawn, and dependant to the unpredictable, actively psychotic, aggressive, and demanding individuals. It is reported that a high concentration of the chronically mentally ill exist in Edmonton due to the close proximity of two major Provincial Psychiatric Hospitals (Alberta Hospital Edmonton and Alberta Hospital Ponoka) as well as the psychiatric units of four general hospitals.

AMHMPS reports indicate caseloads for the rehabilitation clinical staff (excluding the consulting psychiatrists) range from thirty to eighty cases per clinician. Referrals to the program are initiated by telephone, contacts with other agencies/providers, letter, inter-regional transfer, and self referral or "walk-ins". Self referral or walk-ins can have an external source (Non Government Organizations, general practitioners, institutions, or police) prompting or directing the patient to the Clinic. An average of twenty walkins per month come to the reception area. Four to six of these are for the Rehab. program. High volume and the nature of patient profiles result in waitlists and restricts the ability to provide follow-up. It is recognized that patients do drop out of or refuse contact with Mental Health Division services or programs. This is a characteristic of the chronically mentally ill who are not well stabilized.

The provisions of the Mental Health Act are an important determining factor in Community Mental Health Patient Profiles. The Act allows for compulsory detention in a psychiatric hospital of patients who are mentally ill, dangerous, and who refuse voluntary admission.

Policies, Procedures, and Practices

Policies and procedures exist in the Edmonton Clinic, addressing Regional processes of referral, intake, assessment, treatment planning, and implementation.

A procedure regarding difficult to manage patients in the waiting/reception area states that the receptionist will call the primary therapist; if unavailable the therapist's supervisor; if unavailable, the intake worker, or any supervisor or therapist, or will engage a warning buzzer. The buzzer sounds in the adjoining Regional Administrative office, notifying similar administrative support staff to respond.

Procedures indicate that only clinical staff will advise patients of wrong appointments or any negative information. In situations where patient behaviour is of concern, it is the therapist's judgement alone which is relied upon to ensure the safety of other patients and staff. Actions available are: removal of problematic patients, patients at risk, and/or staff; involvement of security

or police.

Procedures for intake of referrals/walk-ins exist and outline requirements for each program in the Region. They indicate assurance of professional staff being available for telephone or walk-in referrals. All referrals are to be seen as soon as possible by the Intake Worker to deal with the dangerousness of patients to themselves or others. Outcome is discussed with a supervisor and documented.

Waiting room/reception procedures exist to record arriving patients and to notify therapists/intake workers. The procedure outlines the process for reception to monitor behaviour in the waiting area; who to call if problems arise, when to engage the buzzer and when the receptionist is to leave the area.

Physical Plant / Building Security

The 108 Street Clinic occupies all of the 5th Floor and portions of two floors (6 and 7) as well as a semi-active records storage space in the building's underground parkade. The office tower houses four other provincial government departments as well as private tenants. Alberta Family & Social Services co-occupies floors 6 and 7 of the Mental Health Services' floors.

Clinical offices are arranged in a maze-like fashion on different floors. Therapists are required to escort clients long distances to their offices or, by means of elevator or stairwell, between floors. At any given time, many offices and meeting rooms are vacant with doors open to the internal corridors.

Most therapist offices have "sidelight" windows with drapes and are lockable from the inside. Only a few master keys to all locks are available. Glass on all interior windows (including the reception area) in the Clinic is breakable. Furniture within the offices has been arranged to suit the preference of the therapist. Therapist offices, therapy rooms, and meeting rooms have some soundproofing to facilitate patient confidentiality. The telephone system is a mechanical 1A2 key system. A buzzer allows the clinic receptionist to alert administrative and management staff that a problem exists. No emergency buzzers exist in therapist offices.

Security personnel for the building operate on the main floor from 3:30 p.m. to 11:30 p.m. weekdays and 8:00 a.m. to 4:00 p.m. on weekends. A "lockdown" of the building commences each weekday (from the 11th floor down) at 4:30 p.m. and is completed by approximately 4:45 p.m. The procedure is to ensure that all stairwells and interior access points off the elevator lobbies are secure, the elevators are "down only" without activation by the guard and street entrances are locked. No Security Officers are present after these hours. The building management's presence in

the building is maintenance focused. The management company manages four other buildings in the city, and is therefore not available to provide daytime security services. The parkade levels offer no special security features. While the vehicle access door to the parkade is card operated, the other access points are uncontrolled.

III ANALYSIS

Clinic Operations

The following sections critically review relevant aspects of the 108 Street Clinic's operations.

Program Organization

The structure, goals, and functions of the Rehabilitation Program, its staffing profile, and complement are a generally accepted model for providing service to the chronically mentally ill.

Issues of the physical location of the program, contingency plans in the event of an emergency, training/orientation of staff, procedural requirements, and staff role definition will be addressed below. The important issues of security and physical layout of the Clinic will also be discussed further in this section.

Communication processes and interstaff relationships were reported to have caused frustration at times for Reception, Administrative Support Staff, and Therapists. Expectations, roles, and responsibilities are not always clear. Clerical staff expressed feelings of non-support by some therapists and supervisors in the response to or communication issues around difficult patients.

Client Population

Issues around the patient population concentrated on the number requiring services exceeding the resources available, the need to priorize patient admissions and the resulting high severity of disability among those patients seen at the Clinic.

The concentration of the chronically mentally ill population in Edmonton is perceived by clinical staff as exacerbated by:

1. Maintenance of the de-institutionalization plan of the late 1960's in North America.

2. Edmonton's number of facilities serving a large rural (surrounding and far northern areas) and an urban catchment area.

3. Diminishing general hospital resources and limited or insufficient community resources (residences, day programs, and personnel) to support the non-institutionalized based patients. As hospital bed numbers are reduced, hospitals will occasionally refuse admission of patients referred to them even when on certificate or warrant.

While the authority of the Mental Health Act's certificates last for a few weeks, patients may refuse treatment even when confined. Further, no provision within the Act exists for compulsory aftercare following discharge. This circumstance is perceived by clinical staff to foster an increase in the number of untreated mentally ill individuals in the community.

These patients may be refusing treatment or follow up and present themselves to the rehabilitation team or elsewhere in severe crisis. Currently, community services resources (eg: staff, residential accommodations, day programmes) are insufficient to meet the service demand. It appears that the marginally or nonstabalized patients require more staff time than is available and are then susceptible to further deterioration of their condition. Further, the diminishing capacities of the psychiatric hospitals and local psychiatric units place a burden of often inappropriate referrals upon the community system, or the patients simply fall between the services and receive none.

Alberta Mental Health Management Planning System reports clinical caseloads averaging fifty cases per therapist. There are seen as unsafe by most clinicians (30-35 is usually considered manageable). One successful project (Dane County, Wisconsin) has 12-15 cases per worker for a "total care" program. The Edmonton Clinic caseload situation results in treating first those patients that are pressing for service. Therapists often welcome cancellations or "no shows" as respite.

The staff felt the program is appropriate for the client group but stress the need for:

- Available staff time
- Available residential spaces or supervised "independent" living
- Available crisis response (includes hospital beds if necessary)

Policies, Procedures, and Practices

Compliance to existing policy and procedures is approximate most of the time. Due to situations around staff and/or patients as well

as physical layout of the Clinic, an informal or compelled deviance to policy or procedures is often utilized rather than compliance.

Policies in and of themselves are interpreted differently by individuals. They are felt by some as inhibiting necessary action. Orientation to policies occasionally is not complete. While procedures are in place, some gaps are present (eg. what to do after buzzer is engaged) and some are absent when pertaining to administrative support staff (eg. identified back up staff and scope of responsibility). Procedures while documented are not tested. Procedures for problem/issue resolution appear complicated and therefore, do not allow for immediate response to emergencies. Administrative Support staff must vet unusual situation through three or four supervisory levels or Committees for action. Regarding personnel/clinic procedures, staff in general have no system that identifies clinic staff from patients, identifies to reception which patients have appointments, and which therapists are in the Clinic, on home visits or community agency liaison. While the Clinic hours are 8:15 a.m. to 4:30 p.m., clinical staff have flexible hours due to late afternoon or evening work. Clerical/receptionist staff generally keep the official Clinic hours.

On the day of the incident, an informal system response occurred within the Clinic. It deviated from the general policy and procedures with mixed results. When the receptionist took her station, the client was present in the waiting area. He requested to see first, Dr. Sowa and then Inette John. Appropriate policy and procedure of raising his chart and referring him to the intake worker was completed. When the client became verbally abusive and visibly agitated, the receptionist followed procedures and alerted her supervisor. At this point, the informal system began as the intake worker was not in but did arrive after the incident. A male clinician known to be helpful in such situations was summoned but was unsuccessful in engaging the patient. The therapist advised the receptionist's supervisor to phone "Security". Since the supervisor was aware of the unavailability of "Security" or the Building Superintendent, plus that Inette John was the last worker on this case, she requested Inette John to alleviate the situation in the waiting area. Ms. John, sensitive to the needs of both patient and receptionist staff, chose to be informal and see him because she knew who he was (she had not seen him for two years).

At this point all those involved, viewed the situation as typical and not requiring special action:

- Discussion with Family & Social Services Social Allowance Worker and Supervisor also indicated frequent exposure to such behaviours.

- Discussion with Ms. John's supervisor supported the view of a satisfactorily performing staff, very conscious of personal

safety with patients but very willing to help fellow staff or patients.

- The client was a patient of both Dr. Sowa and Inette John at the Clinic. He was on record as choosing to withdraw from their care as well as the Approved Home Program and Residence. An audit of the patient's file indicates two admissions to Alberta Hospital Edmonton due to suicidal risk and auditory hallucinations.

- No evidence was present on the file to predict homicidal violence. Ms. John came out to the waiting area, checked the file and escorted him to her office, where he fatally stabbed her.

Professional staff responded according to their training and experience while clerical staff sounded the alarm. No policy, procedure, or contingency plan exists for such an incident. Overall, the staff response was appropriate under the existing conditions.

Security/Physical Plant

While the physical layout of the Clinic did not create or in any way invite the August 27, 1991 incident, many instances can be cited where the physical features did not assist in the intervention and safe conclusion of the incident. They are:

Inette's Office:

- Lock on door was locked by patient from the inside in order to keep the Clinic staff from intervening/assisting. Few master keys meant confusion and delays with respect to eventually getting the door open.

- Interior window on Inette's office had the drapes closed presumably for either personal privacy or client confidentiality, or both. This did not facilitate observation of what was taking place within the office.

- Inette's office furniture was arranged with the desk close to the exterior window and other furnishings so as to allow only the patient quick exit. The patient would have been seated between Inette and the door.

- There was no method (alarm or buzzer) for Inette to alert other staff of her predicament, once trapped within the office.

General Clinic:

- The incident was by definition an "intake" situation. As the behaviour of an intake patient would be unknown to the therapist, there is considerable risk involved in meeting with that patient. As the Clinic did not have a designated intake room off the reception area equipped with observation or exit capabilities, Inette had no other option but to see the patient in her office.

- During the incident, one important area of activity was the evacuation of staff and other patients from the area. The 5th floor location was not conducive to doing this efficiently. Pulling the fire alarm to evacuate the floor would have also evacuated the building and would have possibly increased risk to others. Lockable offices were used to secure those who could not leave the area.

- As various staff became aware of the incident, numerous calls were made to 9-1-1. Although it is reported that lines were "jammed" or there were insufficient lines available, it is still unclear as to whether the problem was with 9-1-1, with 108 Street Building phone system, or both.

- The "office tower" level of security was insufficient for the operations of the Clinic. There was no intermediary between the Clinic staff and the police. Building management and security were unavailable and unable to meet the security response needs. By default, male clinic staff were faced with this role and responsibility and had to place themselves at risk.

The following factors are identified not because they were specifically relevant in the incident but because they could well be relevant in a future incident:

- The waiting area is open to the public when the building opens in the morning. Staff must enter/exit the reception area by passing through the patient waiting area. The reception area is glassed in with breakable glass and is physically remote from the rest of the work areas. There is no means for escape. If the receptionist calls for help she is readily overheard by the patient.

- The physical layout of the Clinic allows numerous avenues of unauthorized access into clinical and secretarial office areas, file room, photocopy/work room, and staff lounge.

- Staff working in the photocopier/workroom have no security at all from the waiting area.

- Staff exiting the building into the parkade are unprotected in the elevators, stairwells, and the parkade itself.

Incident

Placing the Clinic in the context of the larger mental health/ service system (culture), one can suggest that a tragedy can occur because of some inaccuracies or inadequacies in norms or beliefs held by clinicians (eg. "I can control the situation", patients respect therapists).

In a busy downtown clinic with a number of staff, high caseloads and emergent client crisis, the complexity of its operation require clear structure and operating procedure including a specification of roles and responsibilities. Some of these are outlined in memos and policies, while many of the established procedures of the Clinic have evolved informally and are based on the habits and preferences of individual staff.

Staff members responded to the incident in a concerted way, using their best judgement and courage. Tasks duplicated by various individuals reflects the absences of emergency response plans and contingencies.

Often therapists develop beliefs and attitudes that are at odds with the reality of the hazards of their profession. These build up over time and go unnoticed, are accepted, or not understood until after a tragic event.

IV REVIEW OF INTERIM RESPONSES

Immediately following the incident of Ms. John's homicide, numerous risk management/security activities were initiated or completed. The Regional Director outlined the Interim Response in his memo to staff dated September 5, 1991.

The following steps have already been undertaken by the 108 Street Clinic and implemented as of this writing. This committee strongly supports these responses to the security issues of the Clinic.

Interim Response

- A security guard was hired and stationed in the waiting area of the Clinic from 8:00 a.m. to 5:00 p.m.
- Staff identification badges are now worn by professional and clerical staff.
- Policies and procedures have been reviewed.
- Limits for acceptable client behaviour have been set for the waiting room area of the 108th Street Clinic.

- Walk-ins are seen in the former glassed in play area of the waiting room.
- More than one clerical staff is to be present in the glassed in reception area.
- After hours staff are to leave in pairs.
- Staff are to go to the isolated storage file room in pairs.
- Difficult and intimidating patients are seen by two therapists.
- Therapists are to walk behind patients when escorting them to their offices.
- The doors to the therapist area are now locked and keys have been issued to all staff.
- The door to the Reception counter is locked.
- Window between the Receptionist and the waiting area is partially closed.
- Records room now has only one access from the waiting area to facilitate observation.
- Photocopy machine is located to afford observation of waiting area, while photocopying.
- Staff are encouraged not to use public washrooms, but utilize the special needs washroom.
- Some therapists have re-arranged furniture in offices to allow easy exit and open observation of corridor via side lights or wall glazing.

Edmonton City Police Review

The Edmonton Police Services assessed the 108 Street Building and Clinic security and practices. Please refer to Appendix I for the full report and recommendations.

The Committee reviewed these recommendations and examined their feasibility and implications. Some of the recommendations have been implemented by Regional Management and others are also included in this Committee's recommendations. The Committee recognizes the Edmonton City Police Report as an incremental approach rather than addressing the overall design of that clinic. Below is an assessment of this report.

- The first eight recommendations deal with exterior and interior physical aspects of security. All four of the recommendations listed under the heading of Exterior and the first and fourth recommendation under the heading of Interior rely on building management. The Committee supports these recommendations.

- Recommendations two and three under the heading Interior are supported by the Committee and are currently being attended to.

- Under the heading Reception Area 5th Floor. Recommendations one, six, and seven have been responded to, and are supported by the Committee as interim responses.

    - Recommendation three recommends is that the storage area with the photocopier and paper supplies remain locked and the door closed even when in use. There has been an alternative response by moving the photocopier so that the operator's back is not to the door and the operator has a view of the Receptionist area. The Committee is in support of this alternative response as an interim measure. The Committee supports that recommendation two be addressed.

    - Recommendation four in this area is that panic buttons be installed in two different locations behind the counter area. The Committee supports the concept of panic buttons but believes that it needs to be looked at from a holistic perspective and will be attending to this issue in the larger security report.

    - Recommendation five suggests that the reception area staff be alerted prior to the patient's arrival if the subject has been identified as violent. This recommendation, in the Committee's view, cannot be implemented because of the unpredictable attendance of clients at the Clinic. Where potentially violent clients are scheduled, the recommendation is supported.

- Under the heading Reception Area Interview Room recommendations two to five are being carried out and are supported by the Committee. Recommendation number one requires implementation.

- Under the heading, Staff Areas, 5th Floor and 6th Floor, recommendation one is not being implemented because the Therapist area has been locked off. Recommendations two to eight are being implemented and are supported by the Committee. Recommendation nine has already been addressed and a resolution to the washroom situation needs to be determined. Recommendation ten in this area as well, is supported by the

Committee, but again will be attended from a holistic perspective. Recommendations eleven and twelve require further review.

- Under the heading Administrative Area, all three recommendations are supported and are being implemented.

- Under the heading, 7th Floor Area, recommendation one relies on the co-operation of all the tenants in the building. The Committee supports approaching these tenants to encourage them to ensure that all of their doors are locked. Recommendation two requires that two staff members should be present when the kitchen is in use. At this time there is always one staff member in the immediate area and one in close proximity. The Committee believes that the Therapists involved need to use their discretion with respect to this recommendation.

Administrative Support Staff Security Submission

A memo dated September 4, 1991, from the 108 Street Clinic clerical staff to Edmonton Region's management, outlines numerous security concerns and suggestions for their amelioration.

Some of these suggestions have been implemented while others are currently under consideration. The Committee Chairman has reviewed and reflected where appropriate, these concerns and suggestions in the Recommendations section of this report or forwarded them to the province-wide review phase.

V CONCLUSION

Under the operating conditions at the time of the incident, the tragedy of Inette John could not have been predicted or prevented. The Committee believes, however, that the implementation of the recommendations contained in this report will reduce the risk to the 108 Street Clinic staff in the future.

VI RECOMMENDATIONS

The Committee supports the previously reported Interim Response actions including those of the Edmonton Police report, and will repeat them as appropriate in this section as well as provide additional recommendations. The following are not presented in order of priority.

1) The security guard hired and stationed in the Clinic waiting area should be maintained until the recommendations of this

report have been reviewed and appropriate security measures are implemented.

In the longer term, use of security staff will be determined by the Region Director, in consultation with the Director Community Clinics Branch and with the approval of the Division's Assistant Deputy Minister.

Explore feasibility of combining security and reception duties in one position.

2) Administrative and professional staff should wear identifying badges. Applicability of this practice across the provincial clinic system will be reviewed.

3) Clinical and administrative policies or procedures relating to all aspects of clinic therapist and client security need to be clearly established, disseminated and regularly reviewed/updated. Ensure clear lines of responsibility/accountability and contingencies are in place for handling a range of potential emergencies such as:

- Limits for unacceptable client behaviour for clinic therapists and reception staff.

- Contingency plans for difficult and/or intimidating patients (eg. more than one clerical staff present in reception area, two therapists interview/manage the patient, back-up security, safety exits).

- Security standards must include services provided outside of the Clinic (eg. home visits).

4) Staff training/orientation at all levels should include:

- Clear communication of all relevant safety/security policies and procedures. Steps must exist to ensure adequate training and familiarity in the execution of these procedures. This includes appropriate training practices and drills for timely and satisfactory response to activated distress calls. Adherence should be monitored semi-annually.

- Training activities at all levels for increasing awareness and sensitivity to danger, assessment of dangerousness, personal safety, individuals role in clinic emergencies, availability of security/back up and the use of police services.

- Special focus on improving receptionist orientation/education of safety/security issues.

- Exploration of paraprofessionals for reception duties.

5) The Clinic should be relocated to a main floor, "store front" location close to the patient population. Design and construction should follow the particular requirements of a mental health clinic. eg.:

   - User friendly location.
   - Security minded intake office near reception.
   - Visually open offices.

   In the short term, existing clinic requires redesign and modification to waiting area, including:

   - Appropriate (accessible and secure) intake room.
   - Replace breakable glass with safety glass.
   - Allow access from reception area without passing through waiting area.
   - Internal clinic access only to photocopy/work room.
   - Allow access from file room without passing through waiting area.
   - Replace telephone system with emphasis on staff safety features.

6) Pending outcome of, or in conjunction with #7, review available options and subsequently implement an appropriate alert or alarm system, accessible by all clinic staff.

7) Review the conflicting priorities of client/file confidentiality and staff safety with regards to the locking of each therapist's office. Examine alternate arrangements/standards for file security. Change locking mechanisms on therapist's doors to remedy malicious or inadvertent locking/unlocking, or remove locking mechanisms completely if office area in general is secure.

8) Improve overall building security by implementing specific recommendations submitted by Edmonton Police Services and/or will be recommended by Public Works Supplies & Services. This would address such issues as public/staff washrooms, arrangement of office furniture escape routes, access patterns, observation access, precautions re: physical layout, methods of escorting patients, and after hours support.

9) Ensure that reception area has knowledge of intake schedule

and therapist's whereabouts. Protocol for seeing "walk-ins" or emergency cases needs to be established and implemented. Ensure that reception is alerted to problematic incoming appointments. Sub-teams must know the location of therapists' home and agency's visits and time of return.

10) Ensure that intake function and availability is scheduled to coincide with office hours, without exception.

11) Review of Critical Incident Debriefing mechanisms for staff and clients when appropriate, to ensure that these are activated promptly, according to established processes and with the aid of external peer resources.

12) Disaster evacuation, or clinic safety emergency plans need to be established and training provided.

13) Parkade filing storage room requires a security/safety solution.

14) Intake policies (ie. patients whose files have been closed for more than three months must be seen by the intake therapist) should be maintained for compliance and reviewed for effectiveness.

15) Establish mechanisms (ie. special patient listings, special notice protocols between Agencies) for interagency communication and collaboration in identifying, notifying, and informing one another of high risk or more severely ill clients (eg. Alberta Hospital Edmonton, Psychiatric Units, Alberta Family & Social Services, etc.).

16) Increase access to higher levels of care through collaboration or liaison with twenty four hour care facilities. This would assist in stabilizing the more disturbed/higher risk patients while the clinic staff remain the primary caregivers in the Community.

17) Review existing caseloads, priorization practices, utilization rates, referral sources, staffing, division of labour, role, and objectives of the program. Assess function, role and status in regards to the larger mental health system in Edmonton and its stakeholders.

VII SUMMARY

On August 27, 1991, Inette John RN, a Mental Health Therapist of the Edmonton Mental Health Division's Community Clinic, Rehabilitation Team was stabbed to death by a former patient. Appropriate response to the situation occurred due to professional experience, training, and common sense. The organizational

response resulted in a number of policy, procedural, and structural/operational changes to remediate the vulnerable nature of receiving and treating mentally ill patients. It also gave rise to the formation of a Security Review Committee to investigate the fatality and to assess the security of the overall clinic system.

While this homicide could not have been predicted or prevented, the fatality review gave rise to specific recommendations, which may help to further enhance security at the 108 Street Clinic. It also gave rise to numerous issues that require a more global view of the Division's Clinic system, its approach to services, and its relation to other stakeholders.

The Division and its staff will not forget the tragic loss of Inette John. It remains committed to learn from this incident, so staff will be able to safely serve the chronically mentally ill.

Submitted by:

Security Review Committee
Alberta Health - Mental Health Division

Chairman : D. E. Ehman

APPENDIX I

EDMONTON CITY POLICE REVIEW

EDMONTON
POLICE
SERVICE

9620 - 103A AVENUE
EDMONTON, ALBERTA
CANADA T5H 0H7
PH: (403) 421-3333
FAX: (403) 425-9063

Address all replies to Chief of Police

0400-1
x0705-1

1991 September 11

Penny GILL
Community Psychiatric Program
5th Floor, 9942 - 108 Street
Edmonton, Alberta
T5K 2J5

Dear Penny,

The following recommendations for improved security for employee safety at 9942 - 108 Street are listed below.

Exterior:

1. Mercury lighting to be installed on the upper North, South and East exterior walls to provide better illumination during evening and early morning hours.

2. One mercury light to be installed over the South/West government parking area.

3. The one minute timing span for entry to the underground parking lot should be reduced to forty-five seconds.

4. Exterior patrols by Building Security after hours to accommodate late night meetings.

Interior: (Main Floor, underground parkade)

1. Four card readers to be installed, two on the main floor access doors to the garage and two more on the basement access to the garage from the elevators.

2. When files are required from the basement store room a buddy system should be instituted and strictly enforced.

3. When late night meetings are required, at the conclusion, staff members should attempt to leave the office area in pairs or groups.

4. Interior patrols by Building Security after hours for the Parkade.

Reception Area 5th Floor:

1. Reception area enclosure should remain closed and locked at all time.

2. Reinforcing of the glass around the reception area to prevent the glass from shattering when objects are thrown at them.

3. Storage area with the photocopier and paper supplies to remain locked and the door closed even while in use.

4. Panic button to be installed in two different locations behind counter area.

5. Reception area staff to be alerted prior to patient arrival if the subjects file has been tagged for violence.

6. Reception staff will no longer send patients to staff offices without the patients being met or accompanied by staff members.

7. All doors leading from the reception area to staff office, adminstration or medical rooms will remain locked at all times.

Reception Area Interview Room:

1. Reinforce the windows to prevent breakage.

2. Remove all furniture except what is needed.

3. Subject should be place with his or her back towards the exterior windows, staff members near the door to control the exit.

4. Two staff members should interview new patient.

5. If drapes are to be used the glass door should remain uncovered, this will permit viewing by other staff if trouble begins.

Staff Areas 5th and 6th Floors:

1. Coffee room to remain closed and locked to prevent unwanted mixing of staff and patients.

2. All offices when not in use will remain locked, this also includes conference rooms, medical rooms etc.

3. Staff members when meeting patients in the reception area will walk behind the patient not in front when returning to the office.

4. Remove excess chairs from all rooms, leave only what is needed, if more chairs are required bring some in but remove again on completion of interview.

5. Remove flower vases, spike type note holders, knife letter holders. etc.

6. Set the staff offices up for security, when interviews are conducted the patient should be the furthest from the door. The patient should be, in the case of the exterior office, closest to the windows and the desk should be between the staff member and Patient. The staff member should control the exit point.

7. The drapes should be left slightly open so that passing staff can see if there is any trouble.

8. Two staff members should interview a patient with the history of violence or their file has been tagged with a caution.

9. If a patient requires the use of a washroom the staff member will escort the patient out of the staff area to the designated patient washroom. Washrooms on the 5th Floor should be designated for patient use, while the washrooms on the 6th and 7th Floors should be designated for staff use. These should be secured with a key access to prevent unwanted mixing of staff and patient.

10. Panic buttons should be installed in each office and all staff should be aware of what the panic alert sounds like and what is expected of them when the alarm is sounded.

11. The typing area should have a half wall with a glass upper portion. This area should also have a half door to prevent unwanted entry by patients.

12. Between the typing area and late night or weekend meetings location there should be an access control door which can be closed and locked to stop patients from wandering. All doors should be controlled by one master key issued to each staff

Administration Area:

1. This area should remain out of Bounds to all Patients except when escorted by staff members.

2. Staff members will discontinue the practice of using the reception area as a short cut to the administration area.

3. All rooms in the administration area will remain locked when not in use.

7th Floor Area:

1. All doors to remained locked when not in use.

2. Two staff members should be present when the kitchen is in use.

This is the conclusion of the Security review, if you have any questions or concerns please contact me at 421-3550. While I can point out the areas for improvement of Security. Common sense I believe is the greatest asset for Security in this case.

Sincerely,

Chuck Prince

Cst. Chuck PRINCE
Business Security Liaison
Crime Prevention Unit